EAR
NOSE
THROAT
ENT and Allergy Center

PATIENT INTAKE

Patient Name _____ Date of Birth _____

Mailing Address _____

City _____ State _____ Zip _____

Daytime Phone Number _____ ☐ Home ☐ Work ☐ Cell Okay to Text? ☐ Yes ☐ No

Age _____ Sex: ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ W ☐ D ☐ Sep SSN _____

Employer _____ Phone _____

GUARDIAN OR SPOUSE INFORMATION

Name _____ Date of Birth _____

Mailing Address _____

City _____ State _____ Zip _____ SSN _____

Employer _____ Phone _____

EMERGENCY CONTACT (OUTSIDE OF HOUSEHOLD)

Name _____ Home Phone _____

Relationship _____ Other Phone _____

HOW DID YOU HEAR ABOUT US?

☐ Patient ☐ Primary Care Physician _____ Phone _____

☐ Other Physician–Which One? _____

RELEASE OF INFORMATION **☐ STRICTLY CONFIDENTIAL**

The ENT and Allergy Center has my permission to release MEDICAL information to the following:

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

The ENT & Allergy Center has my permission to release BILLING information to the following:

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

INSURANCE INFORMATION

Insurance Company _____ ID# _____ ☐ Group ☐ Self-Funded

Policyholder Name _____ DOB _____ SSN _____

PATIENT PORTAL

To access the patient portal, go to www.entnwa.com and select patient resources. From this menu, choose patient portal and follow the prompts.

AUTHORIZATION AND ASSIGNMENT - INITIAL EACH OF THE FOLLOWING

_____ I have received a copy of the ENT and Allergy Center Compliance Final Patient Privacy rule part 164 HIPAA.

_____ I understand that it is my responsibility to notify the ENT and Allergy Center in writing of any changes to the above permissions.

_____ I hereby authorize ENT and Allergy Center to furnish information to Medicare and other insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself and my dependents. I understand that I am responsible for any amount not covered by insurance.

Signature _____ Date _____

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MEDICAL HISTORY FORM

Date: _____

Date of Birth: _____

Name: _____ Email: _____

I consent to the email delivery of all information, including protected health information under HIPAA ☐

List your allergies to medicines:

☐ No drug allergies ☐ Penicillin ☐ Sulfa ☐ Codeine ☐ Anesthetics

☐ Other _____

Race / Ethnicity

☐ White ☐ African / American ☐ Hispanic ☐ American Indian ☐ European ☐ Asian

☐ Other _____

Preferred Language ☐ English ☐ Spanish ☐ Other

Do you take any medications?

☐ Yes ☐ No If yes, please list _____

Do you have the following?

☐ Diabetes ☐ Hypertension ☐ Heart Disease

List any other medical conditions _____

Do any of the following conditions run in your family?

☐ Bleeding Tendency ☐ Allergy Tendency ☐ Diabetes ☐ Hepatitis B ☐ Hearing Loss ☐ Heart Disease

Alcohol / Tobacco Use:

☐ Alcohol _____ oz / day ☐ Smoke _____ packs / day ☐ Smokeless Tobacco ☐ Former Smoker

Do you have second hand smoke exposure? ☐ Yes ☐ No If yes, please check: ☐ Home ☐ Work ☐ Social

May we contact your pharmacy to get your medication history? ☐ Yes ☐ No

Preferred Pharmacy: _____

List any surgeries you have had _____ ☐ None

Do you have any of the following symptoms

Constitutional:	☐ Night Sweats	☐ Fatigue	☐ Weight Loss
Eyes:	☐ Blurred Vision	☐ Double Vision	☐ Eye Pain
Heart:	☐ Chest Pain	☐ Heart Palpitations	☐ Swelling in Legs
Lungs:	☐ Cough	☐ Spitting up Blood	☐ Shortness of Breath
GI:	☐ Nausea	☐ Acid Reflux	☐ Difficulty Swallowing
Joint:	☐ Joint Pain	☐ Joint Swelling	☐ Muscle Cramps or Weakness
Hematology:	☐ Easy Bruising	☐ Blood Clots	☐ Lymph Node Enlargement
Skin:	☐ Rash	☐ Skin Cancer	
Psychiatric:	☐ Anxiety	☐ Depression	
Allergy:	☐ Sneezing	☐ Itching/Watery Eyes	

I authorize and consent to my blood being tested for communicable diseases if any person is exposed to my blood or other bodily fluids at the ENT and Allergy Center. _____ Date _____

2100 N. Green Acres Rd, Fayetteville, AR 72703 • **(479) 521-0455**
www.entnwa.com

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PAYMENT POLICY

You are required to pay for the portion of services that the insurance company deems as your responsibility. This includes deductible, co-pay, co-insurance and any non-covered services. However, you are required to sign that your insurance benefits be sent directly to our office. If for some reason your insurance does not pay as expected, you will be responsible for the balance. All surgical procedures require that payment be made in advance of the date of surgery.

Any other arrangements must be made in advance with the Accounts Manager.

STUDENTS — If you are a University student whose parents will be responsible for the bill, we must contact your parents to verify their responsibility and they will be asked to sign as the responsible party.

MEDICAID — We will file Medicaid as a Primary Insurance if you provide the proper referral from your Primary Care Physician. If you are insured through the Arkansas Kids First Program, you must pay your $10 copay at the time of your visit. If you have a commercial insurance as primary, we DO NOT file Medicaid as a secondary insurance.

WORKERS COMPENSATION — We accept Worker's Compensation patients after benefits have been verified.

LAWSUITS & ACCIDENTS — All patients are responsible for charges incurred regardless of pending lawsuits and/or settlements.

I understand and agree with the above policy.

_____ _____

Patient and/or Responsible Party — Date

_____

Witness

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www.entnwa.com

NOTICE OF PRIVACY POLICY

ENT & Allergy Center
Effective 1/1/2015

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We intend to abide by the Final Omnibus Rule of the HIPAA regulations regarding your **Protected Health Information**, hereafter abbreviated as **PHI**. The term PHI refers to your medical records, billing and payment records, your name, address, date of birth, social security number, payment history, the name of your health plan and account number, and other data that identifies you.

We are permitted by law to disclose PHI to you and to anyone who needs it to carry out treatment, payment, or healthcare operations. We will be required to obtain your signature for authorization to release PHI for most uses unrelated to treatment, payment, and healthcare operations. We will retain your authorization and provide you a copy if you wish to have it. PHI will be provided within 30 days of the written request in hard copy form. Information may be available for transfer onto USB media if the media is provided by the patient. You may revoke your authorization in writing at any time.

We may disclose PHI as required by law to entities including, but not limited to the following:

- Public health activities
- Victim of abuse, neglect, or domestic violence
- Reportable diseases
- Adverse events to medicines
- Work related injuries may be reported to OSHA or your employer
- Criminal investigations
- Orders by the court or law
- Organ donation data
- Coroners, medical examiners, and funeral director's requests
- Certain military or veteran's activities
- Schools (childhood immunizations only)
- Family of the deceased, according to previously signed authorizations

We may use your PHI to contact you for appointment reminders or health information we believe will be of interest to you.

We DO NOT sell or disclose PHI for the purpose of marketing or fundraising.

We may transmit PHI via email to you, if requested. This will only be done after discussing the risk to you and only after a signed consent is received.

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You have the right to:

- Request restrictions on uses and disclosures to your healthcare plan for those services paid out of your pocket
- Request restrictions on uses and disclosures. Other than the above, we are not required to agree with the restrictions.
- Receive confidential communications of PHI
- Inspect and copy PHI
- Request amendments to PHI by submitting the desired changes in writing
- Receive an accounting of disclosures of PHI
- Receive a copy of our Notice of Privacy Policy

You may complain if you believe your privacy rights have been violated. You may call (479) 521-3363 and ask to speak to the Privacy Compliance Officer. We will not retaliate against you for filing a complaint. You may complain directly to the Secretary of Health and Human Services.

We have a legal obligation to maintain the privacy of your PHI and abide by the terms of the notice currently in effect.

We have a legal obligation to notify you in the event of a breach of PHI, unless, after completing a risk analysis as outlined by the Omnibus Rule, it is determined that there is a low probability of PHI compromise.
We have the right to change the terms of this notice. The revised notice will be posted in our lobby and on our website. You may also request a hard copy.

Details of the HIPAA Privacy and Omnibus Rules are available in the Federal Register at your public library.